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Position Paper on Case Management

Fourth Printing

January 14, 2007

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Executive Director/CEO

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Helping Women Take Charge of Their Lives…While Nurturing the Health of Our Village!

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INTRODUCTION:

The ongoing development of the case management process and unit at NMPP is a high priority of my administration. I strongly believe that all of our Case Managers are the backbone of our agency. They are first line representatives of NMPP in the community. As a result of their work, our clients make changes in their behavior and consciousness, thus raising healthy children and families. I wrote this paper originally in 1996 to provide guidance and direction to all our case management functions at NMPP, particularly our Central Harlem Healthy Start case management operation.

The case management process and unit have become strategic due to the emergence of managed care organizations influencing the development of our business. As NMPP transitions from federal funding toward a flat rate reimbursement system with managed care organizations, the Case Manager takes on a larger role. The speed, quality and value creating aspects of your work will drive how resources flow into NMPP.

This position paper was written for all Case Managers and middle management staff. I am slowly learning the nature of NMPP's business. I will look to you to shorten my learning curve. In the coming weeks, I will start my private meetings with Case Managers. While I am learning the child and maternal health business, I bring to NMPP experience from the mental health and child welfare sectors.

I believe there are some case management principles that span all the social work and public health sub professions. This paper is designed to communicate my ideas about these case management expectations. Next week, the management team will begin the chart review process. We will be examining every chart using this paper as a guidepost. We will also use the ***Healthy Start/NYC*** ***Case Reading Outline***. Please make sure all of your charts are in order.

Case Management Process:

My comments concerning case management will follow the structure of HS/NYC **community-based social/health case management model**. I believe that this is an excellent model when working with women from our community who receive late or no prenatal care.

I also believe that adhering to medical or health models are not enough to impact the lives of our clients. Our interventions begin first by identifying maternal and family health problems. However, we must probe further to understand housing, education and economic development family issues that can be addressed by our interventions.

My comments concerning the case management process will follow the above model's stages of development. I will also make some comments concerning the NYMOMS instruments.

I. Intake and Screening/Case Situation:

Ms. Janet Paterson (alias) is a thirty-year old pregnant, unemployed, single mother. She was referred by the President of Community Pride, located at the 2327 West 119th Street Tenant Organization. She has three children. Robert is fourteen and acting out in school, and exhibiting poor attendance. Keisha is seven years old and Rasheen is four.

Ms. Paterson has not received any prenatal care for two months. She is three months behind in paying her rent. Several times, neighbors have called the ACS child protective worker to determine if Ms. Paterson's smaller children were neglected. On both occasions, reports were submitted recommending preventive services for the Paterson family. No decision was made to remove the children.

Robert is presently providing emotional, social and household parenting support for his younger siblings when his mother is out with friends. The NMPP Case Manager noticed during her first home visit that there was no food in the home and the apartment was in disarray. What are the health and social problems with this family? How does the Case Manager work with others to make this family whole again?

II. Intake Assessment:

The NYMOMS instrument helps the Case Manager to gather data about the mother and other family members. However, this instrument does not provide leadership to the Case Manager in making a summary assessment of Ms. Paterson's social/health problems, strengths and other family member needs.

Each Case Manager is expected to develop a summary statement of presenting problems that adheres to the following framework:

1. What is the nature of the core problem?

There are several issues within the Paterson family. The role of the Case Manager is to detect the main two problems that impact on the other health and social issues within the family. Case assessment is a gathering of facts about the internal and external life of the client.

The objective of the Case Manager is to understand the causative factors in the client's difficulty. Is the core problem Ms. Paterson's lateness in obtaining prenatal care? Is the core problem Ms. Paterson's inability to take responsibility for her children and herself? What about Robert? What explains his behavior?

The generic principles in making a case assessment are familiar to those who have ever completed an experiment in a test tube. The scientist selects raw materials (case data, NYMOMS), orders and analyses their components (study), determine their meaning (inference), weighing assets and liabilities (evaluation), and planning interventions (actions). In the human service field like social work, the data is psycho social and not chemical, and the subject of the client guides the inquiry, but the process is the same as in scientific investigation.

2. What is the severity of the problem?

The Case Manager must come to a conclusion concerning the severity of each problem identified. **This knowledge will help in the planning of different types of interventions to meet the severity level of each problem.**

During the intake interview with Ms. Paterson, the Case Manager should probe concerning Ms. Paterson's past performance in enrolling in early prenatal care during her past pregnancies. What are Ms. Paterson's beliefs about early preventive health care for her entire family?

Does Ms. Paterson smoke? When Ms. Paterson attended prenatal visits, how many appointments did she keep? Did any of Ms. Paterson's children suffer from low birth weight? Does Ms. Paterson show any signs of substance abusing behavior? Has the children's father been involved in the family system?

Why is Robert playing the main parenting role in this family system? How does this impact on his acting out behavior in school and the community? Is Ms. Paterson on public assistance?

Does she have the ability to budget her income? What job readiness or employment skills does Ms. Paterson possess? Or is the nature of the problem, the use of scarce household income on personal antisocial behavior in the community?

3. How long has the problem persisted?

The length of time a problem persists has treatment planning implications. If the Case Manager learns that Ms. Paterson has waited six months to receive prenatal care during the birth process for Rasheen, this will provide the Case Manager with intelligence concerning the difficulty she will face with getting Ms. Paterson in for early prenatal care for her current pregnancy. Regarding substance abusers, it is very important to know how long the client is abusing drugs.

This will determine whether the client just needs detox services and outpatient counseling or a long-term eighteen-month program. Each Case Manager should place time frames on each problem identified in their summary statement.

4. What explains or rationalizes the problem?

The Case Manager now has reached a stage where she must seek explanations for the case facts collected. It is a persistent challenge for the Case Manager to find an effective balance between individualizing clients through assessments and referring this grounded understanding to an **external**, **ever-growing knowledge base about a class of similar clients.**

Healthy Start/NYC has a wealth of national data on why pregnant women fail to enroll in early prenatal care. There is a growing body of knowledge concerning why women stay in domestic violence situations and the appropriate treatment considerations for this problem.

The theoretical knowledge bases on suicide patients, substance abusing pregnant women and adolescent antisocial behavior should be reviewed and studied by each Case Manager. This external body of knowledge can help the Case Manager gain a better **understanding** or **explanation** of why their clients behave in the ways they do. It is at this point that the Case Manager's total reliance upon the raw data to explain the case facts begins to weaken.

The task of the Case Manager is to seek explanation for the case facts collected. What is important here is to employ some base of knowledge, some interpretive assistance that can carry the practitioner beyond the case data. This theoretical base of knowledge can be more reliable than the Case Manger's personal thought system or intuition.

Each case situation can also enrich established bodies of knowledge concerning case problems and solutions. The Case Manager interacts and learns new theoretical knowledge through **training, supervision and continuing education**. This stage is where the Case Manager seeks assistance from his or her supervisor. Also, the Case Manager can make use of training and staff development data to help them in their day-to-day work to use theory to make sense of case data.

I expect all Case Managers and their supervisors to begin to add this section to their case assessment summaries. This will take time. Ms. Renne, Ms. Robinson and I will play a role in helping each Case Manager use theory to make sense of the case data collected.

5. What has been done to address the problem?

At the end of the case assessment summary, the Case Manager should make a statement concerning how the client is functioning. What are the strengths and limitation in the client's situation? What are Ms. Paterson's capacities or resources? What has Ms. Paterson done to resolve her parenting, maternal health and household management problems? Possibly, the Case Manager can contact former social workers to mobilize them in crafting the new treatment plan.

While Ms. Paterson has many problems in her household there is still the question of how the client functions despite her problems. Two people have a broken leg, but one person starts to walk earlier than the other. Human beings have differing capacities for growth and development. This process begins to individualize the case more.

Although Ms. Paterson is on welfare, the Case Manager discovered that she had worked as a legal secretary for three years. This information can be used to develop a plan to eventually get Ms. Paterson off welfare. After the second visit, during the first month of case activity, the Case Manager discovered that the family has a relative and neighbor who played a supportive role for the Paterson family. How will the Case Manager use this information to develop the service plan?

Intake Assessment Pointers:

1. The Intake Assessment should be completed within fifteen days of first contact.
2. At least one home visit should occur to complete the intake.
3. Progress notes should be written for each case contact summarizing intake activity.
4. Progress notes should be handed to the supervisor at the close of business every Friday for review and approval.
5. The Case Manager should check to see if there is any contradictory information collected from the client that could influence the service plan.

6. During the first session, the Case Manager should educate the client about the purpose of the Release of Information instrument and obtain her signature.
7. Each Case Manager should receive at least one hour of supervision per week.
8. All NYMOMS instruments should be completed within thirty days after the first visit.
9. Each Case Manager should prepare two cases per quarter to be reviewed during the case conference session.

10 The HS/NYC activity log should be completed after every case contact.

III. Service Plan Construction:

The assessment process outlined above provides the Case Manager with information to construct a service plan for the client family. Understanding a case is not enough; all analysis must lead to action!

Service plan interventions cannot be haphazardly introduced. The service plan should be based on supporting evidence, inference, evaluation, and a well-defined problem definition. Client treatment outcomes are more predictable, rather than being subject to chance when the plan is based on a real assessment.

Developing client goals is the first step to constructing a service plan for the Paterson family. The assessment process documents the current status of the family. Goal development plots the desired situation Ms. Paterson and the Case Manager want to achieve.

Developing the service plan and crafting client goals should be a joint undertaking between the Case Manager and the client. One of the biggest mistakes a Case Manager can make is **confusing service interventions for goals**. ***The Case Manager will tell you that the service plan goal is to enroll Ms. Paterson in a drug treatment program. Or the goal is for Ms. Paterson to enroll into parent training. These are really interventions that might achieve some behavioral or consciousness outcomes in the client's functioning. Just because Ms. Paterson enrolls in a drug treatment program does not mean she will become drug free! Or for that matter, her participation in a parenting skills program does not mean she will be exhibiting appropriate parenting behavior after she graduates.***

Goals should be written in the context of how the client will transform the problem situation described at the assessment stage. I would like to present a goal setting format called **SMART**. The "smart" format describes five variables that the Case Supervisor can use to evaluate each Case Manager's goal statements.

Specific: All goal statements should be specific to the nature of the problem identified. **Goals should not be methods or tasks that the client or the worker will carry out!** All goals should be behavioral, consciousness or systems change outcomes that can be measured later.

Measurable: All goals should have the ability to be measured behaviorally.

Achievable: Case Managers (CM) should write goals with their clients that are achievable. The Case Manager should stretch our clients to become better human beings. Our interventions and referrals should provide the client with enough internal motivation to take a leap of faith and appropriate action.

Realistic: While we want Ms. Paterson to **be all she can be,** we should not set goals that are unrealistic based on the client's current level of functioning. Some clients can be negatively affected emotionally by not achieving their goals. The good Case Manager will set goals with their clients that manage the boundaries between appropriate, realistic and achievable health and social outcomes.

Time Framed: All goals should have specific time frames assigned to them. Time frames set the context for the treatment process. They provide leadership to the Case Manager to assemble tasks, referrals and interventions (dose) to bring about desired behavioral change.

The service plan should have three components. A clear problem statement taken from the assessment section of the chart is the first component. The second component should be the goal statement. The final section should list the tasks, interventions and referrals the client and the Case Manager will carry out to bring about behavioral change. The Paterson family case situation will be used to operationalize the theory presented above.

Service Plan Paterson Family

Problem # 1: Ms. Paterson has been pregnant for two months. She has not received prenatal care for two months.

Goal: Ms. Paterson will come to an understanding concerning the importance of prenatal care to have a healthy baby. She will attend two prenatal care visits by the end of her first trimester by September 30, 2001. Subsequently, she will attend all of her visits for the next two trimesters to improve the chance of her baby being born full-term.

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Tasks: CM will provide Ms. Paterson with information indicating the importance of prenatal care.

CM will show Ms. Paterson pictures of a newborn baby whose mother failed to receive prenatal care.

CM will refer Ms. Paterson to the Harlem Hospital prenatal clinic. After each successful and verified visit to the prenatal clinic, CM will provide Ms. Paterson with a client incentive package.

CM will carry out the above interventions after receiving the doctor's report on Ms. Paterson's first trimester medical status. The intervention plan will change based on the nature of Ms. Paterson's performance and medical status report.

Problem # 2: Ms. Paterson smokes twenty cigarettes a day during her pregnancy. If this situation continues, it can have a negative impact on the health of her newborn child.

Goal: Ms. Paterson will begin to question the use of cigarettes during her pregnancy and will reduce cigarette use to ten a day by the end of the first trimester, five by the end of the second trimester and quit by the end of the third trimester.

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Tasks: CM will refer Ms. Paterson to NMPP's smoking cessation group that meets twice a week.

CM will learn from her supervisor, relapse prevention techniques. She will use this addiction reduction framework in two sessions a month with client.

Ms. Paterson will communicate to group and CM the problems and prospects of meeting her cigarette use reduction goals.

CM will use NMPP's client incentive program to reward Ms. Paterson when she achieves each milestone in her plan.

CM will deploy relapse prevention techniques if Ms. Paterson resumes her smoking behavior.

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Problem # 3: Ms. Paterson is experiencing difficulty managing her household responsibilities, budgeting household income and providing leadership and emotional care for her children.

Goal: Ms. Paterson will assume full responsibility in managing the affairs of her household and learn the skills to parent and meet the varied needs of her children by March 30th, 2002.

Tasks: CM will work with client to develop a household budget and teach client the skills to live within her budget.

CM will begin to challenge Ms. Paterson's beliefs about emphasizing socializing outside of the household rather than providing love, leadership and sustenance for her children.

CM will contact welfare office to make sure client takes responsibility for meeting the requirements of her face-to-face session thus sustaining her welfare and Medicaid benefits.

CM will work with client and the welfare office to obtain an emergency payment to address back rent issue.

CM, with the assistance of her supervisor, will make the decision whether to enroll client into a parent training class during the second trimester or once client has newborn.

CM will work with client to make her understand why her son, Robert, should end his role as the primary parent so he can reassume his role as an adolescent.

CM will encourage and help client organize appropriate family sessions, trips and activities with her smaller children.

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Problem # 4: Ms. Paterson's husband has not participated in the social life of his family.

Goal: By the end of the third trimester, Mr. Paterson will be in the delivery room and more importantly, interact with his older children and the newborn by providing economic, emotional and social support. This will occur at least three times a month.

Tasks: Ms. Paterson will help the CM locate her husband who is living five blocks from her household.

NMPP's Male Involvement CM will accompany CM and attempt to engage Mr. Paterson and build a relationship.

Mr. Paterson will be encouraged to attend NMPP's Male Involvement Group once a week and be influenced by the curriculum, group process and activities.

CM will counsel Ms. Paterson in drawing up a father involvement contract with Mr. Paterson.

Mr. Paterson will attend first prenatal care visit during the third trimester with Ms. Paterson.

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Problem # 5: Ms. Paterson's job readiness and employment skills are poor and she has only two years before she is terminated from public assistance.

Goal: By September 30th, 2002, Ms. Paterson will be working in a secretarial job paying $18,000 a year, thus meeting the social and health needs of her family.

Tasks: Ms. Paterson will enroll in NMPP's Harlem Works Job Readiness Computer Training Program three months after the birth of her child. Ms. Paterson will learn various productivity software packages as well as the benefits of reporting to work on time, getting along with fellow workers, and taking the initiative on the job.

Ms. Paterson will initially obtain part time employment assignments at temporary agencies to test her new skills.

Ms. Paterson will learn how to develop her resume and contact her old employer to see if they are interested in rehiring her.

Ms. Paterson will learn how to deal with being rejected during the interview process and develop the stamina to stick to the plan to achieve her employment goal.

I could go on and address the needs of Robert and the other children in the household. Goals can be constructed to increase immunization visits, plot the decrease in low birth weight babies, project the increase in postpartum and well baby visits, plan for the reduction in prenatal lead exposure and set breast feeding objectives.

Since the Case Manager (CM) will not carry out most of the interventions, it will be very important that she has a follow-up strategy with each client referral source. It is the responsibility of the Case Manager to monitor the case interventions of each referral source to measure whether they are helping the client achieve their goals. This task is completed by visiting the referral source. Phone tracking and letter writing are other methods.

A professional can usually tell if the referral source is doing their job by examining the client's behavior and consciousness in relationship to their stated goals in the service plan. If the client is still exhibiting historic problem behaviors, the interventions have not worked or the client is not properly motivated to make changes in her life.

IV. Reassessment:

Healthy Start/NYC recommends that the reassessment of the service plan should occur every six months. However, if our agency is to become **"managed care ready,"** we must start the reassessment process at a three-month interval.

Our main goal during the case review process is to examine client functioning based on the incremental projections of goal achievement outlined in the case plan. I recommend that the CM follow the same assessment process mentioned earlier in this paper to complete the reassessment.

The supervisor and CM should be looking to make adjustments in intervention strategies and tactics when the client's behavior has not changed. Sometimes, clients rapidly achieve some of their goals. If this occurs, it is the role of the supervisor and CM to focus in on the other unmet goals and plan the termination process.

In a managed care environment, a client's length of stay will become an important variable to track in terms of utilization management. Ms. Renne and Ms. Robinson will organize a regularly scheduled chart review process and case conference process.

The case conference will benefit the CM and unit supervisor by enlisting the expertise of the entire treatment team in resolving case problems. Twice a month, a case conference will be planned at NMPP. Every six months, the Management Team will launch a review of every chart in the agency. This position paper and the case reading outline of Healthy Start/NYC will serve as an evaluation tool to measure worker performance and client goal achievement.

Case Management Strategy Statement:

Our goal is to reposition NMPP's case management services by upgrading the social work skills of our supervisory and line staff and adopting a clinical approach to delivering child and maternal health services. As we achieve this objective, it will be easier to market our core case management services to managed care organizations and also help NMPP move into other social service sectors where the professionalism of the case management staff is a prerequisite to compete for business.

Supervision:

NMPP has recognized this reality by planning to invest major dollars in a Case Management Training Plan for all staff. Once the consulting group is hired, they will improve staff performance in all of the areas outlined in this position paper.

My presentation will end by talking about executive expectations concerning supervision and a brief statement on quality. Supervision is the core determinate of an excellent or poor case management system. It is the supervisor who provides day-to-day leadership for the CM in clarifying theory, direction and tactics to achieve client outcomes.

The supervisor collects, reviews and approves progress notes, and introduces new bodies of knowledge for the CM to view a case from a different perspective. The unit's performance is usually determined by the skills of the supervisor.

I have outlined a few themes that should occur during a supervisory session. Every Case Manager should receive one hour of supervision per week. **This is mandatory!** From time to time, I will review written supervisory notes.

The supervisory session can cover all or some of the following themes:

1. Follow up on filling out tracking forms and activity logs.
2. Discussion of one to three problem cases.
3. Resolving issues with NYMOMS instruments.
4. Review and discuss progress notes from the previous week.
5. Help CM to write a case assessment or reassessment.
6. Help the CM in preparing for a case conference or management chart review.
7. Discuss and adapt staff training lessons learned to case practice issues.
8. Assist CM to develop observation and interview schedules for field or office visits.

9. Coach and lead concerning treatment considerations for each case reviewed.
10. Assist CM to develop a discharge and aftercare plan for client.
11. Discuss and review executive and program directives and how they impact the Case Manager's tasks.

Quality Assurance:

The child and maternal health industry, like other social service sectors, focus on compliance as its main method to evaluate contract performance. Compliance is an activity where a professional examines whether the Case Manager made the right number of visits for the month, or completed certain paper work tasks at the assigned time frame based on regulations. Compliance does not focus on the behavioral outcomes of our clients after we have administered various interventions. Compliance is intoxicated with process steps.

Quality child and maternal health practices are an examination of the tasks, processes, and results we complete at the intake, treatment and final discharge stages of our work. The thrust to achieve quality child and maternal health practice is an **organizational treatment process and case result.**

The essence of our quality focus is to place the needs of our clients before all other needs and attempt to eliminate mistakes in service delivery. Developing a customer orientation is the first step to develop quality practice. NMPP must continue to define the standards of quality child and maternal health practice.

What is the correct method to complete an intake session, case assessment, service plan or discharge plan? This paper is my first effort to set standards. Quality practice will be able to predict when Ms. Paterson will stop smoking during her pregnancy and adopt behaviors that will bring about planned, appropriate birth outcomes. ***Quality practice is determined and defined by the behavioral outcomes of our clients.***

As NMPP adopts the above focus, we will begin to develop best practice protocols that relate to different cases that arrive at our Intake Department. Our NYMOMS database will eventually provide our treatment teams with statistics on what grouping of interventions brought about the best client outcomes. We can then begin to develop information system modules that can create case assessment profiles and treatment plans by case presenting data for our staff.

Staff training plans should be developed if the worker is not meeting the standards of performance. NMPP will develop a training philosophy of continuous improvement in worker practice.

Since the nature of our business is human emotions and behavior, we cannot expect to achieve total success in the achievement of client goals within set time frames. However, our customers are demanding that the technologies that make up our business **produce better results!**

To make sure that everyone at NMPP understands the quality management process, we will relate staff performance to staff compensation. Staffers that meet the quality mandates will be rewarded. Staffers who fail to meet the quality standards will be coached, motivated, and trained to achieve higher performance levels. Staff who continue to under perform will be terminated. Departments and individual staff members must quickly understand that they **get paid for measurable results or outcomes in their clients' lives.**

This document is now in your hands colleagues. If we stretch ourselves and grow, we can create unprecedented levels of value for our customers. We will also prepare NMPP for the challenges of the new competitive healthcare environment.

If you carry out the case management principles in this position paper, NMPP's case management programs (Central Harlem Healthy Start Program, Asthma Basics for Children, Community Health Worker Program, Baby Steps Home Visiting Program and our Public Health Preventive Services Program) will continue to position themselves as quality, sustainable, outcome-based programs in the market eligible for increased funding.

The turbulence in the industry will force many providers to close their doors. NMPP will be positioned to survive and grow because we are prepared to change not die. Our agency's future depends on what you, the Case Manager, does today.